Sheila Harris, D.D.S.

EXTRACTION
INFORMED CONSENT

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for extraction. Each item should be checked off after the patient (and/or his/her parents or guardians) has the opportunity for discussion and questions.

_____ 1. I, THE UNDERSIGNED, CONSENT TO Dr._____, his/her partners and/or associates performing on me the following extraction: _____ _____ _____ _____, outlined in the treatment plan (*as outlined on the "Treatment Form" that has been provided to me, receipt of which is hereby acknowledged).*

_____ 2. I hereby acknowledge I have given an accurate report of my past and present physical and mental health history; and, reported <u>all</u> prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, body diseases, gum or skin reaction, abnormal bleeding or any other conditions related to my health

_____ 3. I accept and understand the purpose and the nature of the extraction procedure. I also accept and understand what is necessary to accomplish the removal of the tooth/teeth, and all alternatives to this treatment have been <u>fully</u> explained.

_____ 4. I accept and understand that if nothing is done, any of the following, but not exclusive of, could occur:

Bone disease; Loss of bone; Gum tissue inflammation; Infection; Sensitivity; Looseness of teeth, followed by evolution of the tooth; Temporomandiblar joint (jaw) problems; Headaches; Referred pains to the back of the neck and facial muscles; or, Tired muscles when chewing.

_____ 5. The extraction procedure has been <u>fully explained to me</u>, including all risks and complications involved. I have been fully informed that the risks and complications (the exact duration of which is undeterminable and potentially irreversible) may include, but are not exclusive of:

Pain; Swelling; Infection and discoloration; Numbness of the lip, tongue, chin, cheek, or teeth; Inflammation of a vein; Injury to teeth present; Bone fractures; Sinus penetration; Delayed healing; and/or, Allergic reactions to drugs or medications used.

_____ 6. I accept and understand that this extraction can be performed under:

_____ a. local anesthesia/injections
_____ b. oral sedation
_____ c. IV sedation
_____ d. general anesthesia

_____ 7. I accept and understand that I elect to have the extraction procedure under:

_____ a. local anesthesia
_____ b. oral sedation
_____ c. IV sedation
_____ d. general anesthesia

_____ 8. I agree not to operate a motor vehicle or any hazardous device for at least twenty-four (24) hours after the extraction procedure. I accept and understand that I must be fully recovered from the effects of the drugs given during the extraction procedure before I am allowed to operate a motor vehicle or hazardous device.

_____ 9. I accept and understand *there is NO WARRANTY or GUARANTEE of any kind as to any result and/or cure*.

_____ 10. I accept and understand that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the extraction.

_____ 11. I accept and understand that excessive smoking, alcohol or sugar may effect gum healing and may result in complications related to healing. I agree to follow ALL home care instructions and to show up for ALL examinations as instructed.

_____ 12. If I suffer injury of any kind as an actual and proximate result of my not following home care instructions, I hereby absolve Sheila Harris, D.D.S. of any and all financial legal liability.

_____ 13. I have had the opportunity to discuss the extraction procedure, and have had an opportunity to ask questions, and am fully satisfied with the answers received.

_____ 14. If, during the extraction procedure, a change in treatment is required to fulfill the complete treatment plan, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian):_____ Date: _____

Patient's (or Parent/Guardian's) Identification: _____

Witness' Name: _____ Witness' Signature: _____ Date:_____

Doctor's Signature: _____Date: _____